PUBLIC REPORT NO. 17

WILLINGDON YOUTH DETENTION CENTRE

JANUARY, 1989

Ombudsman
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INTRODUCTION

In June of 1985 the Ombudsman's Office made a Special Report to the Legislative Assembly of British Columbia concerning the Willingdon Youth Detention Centre. The Report contained thirty five specific recommendations. A follow-up inquiry and report by this office in September, 1986 concluded that there had been full attention given to these recommendations, except for those relating to the inadequate facilities, referred to below.

The Ombudsman's Office continues to investigate complaints from the Centre on an individual basis; and generally we experience an open and constructive relationship with Centre administration, staff and residents.

Some of the problems discussed in our earlier reports tend to be cyclical in nature and require regular review to identify and resolve any new incidents of improper or unfortunate activity. This is the case with the recent self-harm incidents at Willingdon - a concentration of events which has prompted a great deal of public concern over the past two weeks.

Because of the intense public concern over these recent events, it was thought necessary by the Ombudsman's office to investigate and report publicly on the specific self-harm incidents at an early date. The more general concerns regarding the Willingdon facility will be the subject of continuing review by this office, as noted below.

RECENT SELF-HARM INCIDENTS

On Monday, January 9, 1989, the Ombudsman's office was informed that six serious incidents had occurred at Willingdon Youth Detention Centre during the preceding weekend. We were told there had been two attempted suicides by hanging, two attempted suicides or self-harm attempts by poisoning and two incidents in which residents had slashed their arms with sharp objects. These basic facts were confirmed when we contacted the institution. Our enquiries into these six occurrences were expanded when two more attempted hangings took place on the night of January 11th and the early morning of the 12th.

While our office had been aware that self-harm incidents had continued to occur after the widely-reported "rash" of slashings in 1984-85, the events of January 7th-12th, 1989 presented an unusual and alarming situation. These events

received immediate and widespread media coverage, which had an equally immediate effect on the institution, raising the tension levels among staff and residents. We were also concerned, as were staff, that there might well be a "copy-cat" effect. This indeed may have been a factor in the attempted hangings of January 11th and 12th; one of the youths involved stated that his action might have been influenced by the press and television reports.

Our initial investigation was commenced with an intentionally narrow focus: to determine if there were any common institutional causes of the various individual incidents. We expected that a wider review would follow our investigation of the individual incidents and this is now being undertaken.

The eight incidents were:

DATE	APPROXIMATE TIME	NAME*	INCIDENT
Saturday Jan. 7	5:10 p.m.	Bill	slashed
Saturday Jan. 7	6:30 p.m.	Peter Ken	ate floor cleaner
Sunday Jan. 8	12:20 a.m.	Andrew Geoff	attempted hangings
Sunday Jan. 8	8:00 p.m.	Tom	slashed
Wednesday Jan. 11	11:45 p.m.	Bruce	attempted hanging
Thursday Jan. 12	12:25 a.m.	Frank	attempted hanging

*Names used are fictitious.

The initial investigation focused on written reports of security staff, psychological and psychiatric reports, discussions with staff and interviews with the residents involved. When interviewed, the youths tended to find it difficult to cite specific feelings or events which triggered their actions, and some had given different reasons in talking with different people.

Bill, who slashed his arm on January 7th, and Tom who did the same on the 8th in a different part of the Centre, both had a history of this particular behaviour. It is a phenomenon which is not peculiar to Willingdon Y.D.C. Studies have postulated a variety of reasons, such as a release of tension; anger; excitement; to manipulate staff; to gain attention from staff and other residents; and as a manouevre to get out of the Centre to a hospital (either for a change of scene or possibly with the added possibility of being able to escape). Slashing is not generally regarded as an attempt at suicide.

After the incident, Bill told one of the Centre's psychologists he had been tense because of an upcoming court review; however, he told the Ombudsman Officer the "trigger" had been his frustration at what he perceived as an unfair staff decision. Tom had only the vaguest of reasons to give

to our investigator; the psychologist had also been unable to ascertain a specific cause.

Peter and Ken had acted together in eating concentrated soap pellets which they had stolen from the kitchen. One of the youths had initially claimed to have done so in the hopes of "getting high". Both later told our investigator that their actions had been suicide attempts. Both boys had reason to feel frustrated. Peter had just been returned to Willingdon from a less restricted environment because of staff concerns for his safety. Ken had hoped for a visit for which he thought the institution had given and then withdrawn its special permission. Despite the boys' own statements about intending to kill themselves, the psychologist did not regard either of them as suicidal or depressed when they returned to Willingdon from the hospital on January 12th. Neither youth had displayed obvious signs of agitation or depression prior to the incident.

There appears to have been an unacceptable time lapse between the realization that Ken and Peter had ingested a harmful substance and their arrival at Burnaby Hospital. The question also arises as to why floor cleaner pellets, which had been removed from all living areas some months earlier, and which did not appear on the inventory list of the food

services contractor, were so accessible to residents. These questions will be dealt with in more detail with senior staff at Y.D.C., as will the matter of the way in which the alleged withdrawal of permission to Ken occurred.

Andrew and Geoff were found hanging from the bars in their room doors by staff on a routine check. They were cut down within moments of each other. Neither had lost consciousness, but both were checked in hospital and released back to the Centre.

Geoff's recent behaviour had not been particularly remarkable, and although it was known he had harmed himself in the past, there was no obvious indication he might attempt suicide. Geoff's moods change frequently. When interviewed by an Ombudsman Officer he said he was depressed. Just a few days later another of our staff noted he was "up" and outgoing at a group meeting.

Andrew had attempted to hang himself just three weeks earlier. On that occasion he had almost succeeded. At his mother's request, the Ombudsman investigated the circumstances. We found that the incident occurred immediately following a thwarted escape attempt. (It should be noted that Geoff and Andrew had also acted together in

trying to escape.) According to a psychologist, Andrew had not been depressed up until that point. It appeared Andrew might have acted impulsively after being removed from a unit he liked to the "Assessment Unit" as a consequence of his escape attempt. Andrew's mother's assertions that the first attempt was the result of months of verbal abuse and unfair treatment by some staff members could not be substantiated by our investigation.

The psychologist noted Andrew did appear depressed in the time between the attempts. The day following the January 8th attempt, Andrew was certified under the Mental Health Act, a necessary prelude to his temporary transfer to the nearby Inpatient Assessment Unit which is operated by Juvenile Services to the Courts (part of the Forensic Psychiatric Service Commission). Andrew returned to Willingdon a week later. He had been assessed as not being truly suicidal or deeply depressed: nonetheless, an anti-depressant medication was prescribed.

Bruce was cut down from the bars in his door while still conscious and breathing. A hospital check followed, and he was returned to the Y.D.C. The following morning he made a court appearance, and subsequently was ordered by the court to be assessed at the Inpatient Assessment Unit, where he was

interviewed by an Ombudsman Officer. Bruce told our officer that he found the other residents non-supportive, but would not state that he feared any fellow residents. The staff, he said, were "all O.K." He could give no other reason for his action. His court appearance the next day could certainly have created anxiety.

Bruce's community Probation Officer had warned Y.D.C. staff on his entry to Willingdon on a short sentence at the end of 1987 that the youth was scared to be going there for the first time. He was given some special attention, and completed his 30 days without major problems. No warning was given to Centre staff when he was again incarcerated on remand in the new year. His Probation Officer later told Y.D.C. staff the youth had been depressed in his group home; and in the Probation Officer's opinion might well have made a suicide attempt there had he not been incarcerated.

About forty minutes after cutting down Bruce, staff found Frank standing in his room three doors down from Bruce's, with some cloth around his neck. He seemed to be trying to knot the other end to the bars in his door. No hospital check was required. Staff noted the boy had been found only two minutes after a routine check. Another resident later told staff he had talked to Frank at length, and Frank had said he wanted to kill himself.

Frank, like Andrew, faced a long sentence. The psychologist noted the youth worried about his ability to adjust when finally released in 1991. Perhaps the "trigger" in Frank's case was as he told our investigator: he was sad that his brother, whom he had not seen for some time, had been transferred from Willingdon to a camp two or three weeks after Frank's arrival.

In these cases it is indeed fortunate that none of the youths suffered permanent physical injury; however, this type of incident holds the potential for tragedy.

While the eight incidents could not be linked clearly to any common institutional cause, a range of general contributing causes is possible and requires further review and ongoing attention by the Corrections Branch and by this office. The major categories of concern are dealt with in the next section of this report.

GENERAL OBSERVATIONS

Self-harm

The self-harm phenomenon is immensely complex and troubling. A broadly based study into the causes of self-harm should be commissioned, which would use comparative data from facilities throughout British Columbia and across Canada, and trace individual situations over time, both inside and outside the correctional system.

Also, a comprehensive psychological profile of the Willingdon population has not been done since 1984. Significant change has occurred since that time in the age of the youth incarcerated under the Young Offenders Act, and in the cultural and social composition of our communities. Correctional officials can not realistically meet the needs of society and youth in trouble with the law unless they know in detail the categories and proportions of personality types and disorders involved. This information is essential to dealing with the self-harm problem and must be brought up to date.

Victimizing Behaviour

At the same time as the incidents of self abuse were capturing public attention, this office was commencing action on reports it had been receiving about residents at Willingdon being assaulted by other residents. Such assaultive behaviour is sometimes merely the opposite side of the coin to self-harm. Indeed, some of the self-harm incidents were reported to be the result of pressure imposed by other residents. While one activity focuses inward and the other outward, both involve harmfully misdirected energy which might have been spent along different channels had the youth not been incarcerated. It is possible that ideas for reducing one form of this destructive behaviour will have a positive impact on the other. This is a subject of ongoing review by this office, and includes the possible relationship between victimization and gang activities.

A review is necessary of the current correctional preference for regional detention centres which group different types of youth from a particular area. Classification and segregation by age, personality type, gang membership and offence deserves careful consideration as a means of limiting victimization of more vulnerable youth.

Facilities

An obvious area of concern is the ability of the staff to supervise residents adequately, especially at night. The geography of the secure units is such that the residents' rooms are not visible from the staff office. This means that at night the youths can only be observed by staff patrolling the line of resident rooms on a regular basis. Clearly, a resident bent on hurting himself can time his attempt accordingly. By day, this unfortunate physical layout prevents staff from keeping a clear view of all activities, improper and otherwise.

The 1985 Ombudsman Report noted that the Willingdon facility was inadequate in many respects and did not lend itself to easy supervision of the residents. As a result the Report recommended a comprehensive architectural review which would result in a facility that would provide accommodation consistent with residents' needs, and that would "maximize staff's ability to monitor, supervise, control and interact with residents in a secure environment." Full implementation of this recommendation has not yet been accomplished. It is imperative that this happen. By addressing this issue of physical structure it might be possible to reduce the number of incidents of aberrant behaviour whether self-abusive or

victimizing. Improving the visual control staff maintain over residents in the living units would be one way of preventing some unfortunate events from occurring. The current set-up of a staff control room looking down one long hall which leads into a perpendicular hall containing the residents' living units - mostly out of sight beyond sharp corners - make many types of undesirable activity possible, while staff are completely out of the picture until the next routine check.

What is required is structural change - at a minimum, drastic renovation of the present units; more ideally, construction of a new facility - one based on the best and most modern concepts of youth containment facilities. Such a facility would allow for maximum staff-resident interaction. It would be constructed in such a way that staff would not be handicapped in their efforts to be aware of everything that was going on.

Such a facility could also allow for discrete units which took into consideration the different security needs of particular groups of residents. Staff at Willingdon are hindered by the present facility in achieving total functional separation between some of the "heavies" and some of the "victims". There might also be the possibility of

more efficient grouping of those residents considered to be most at risk of self-harm. This would allow for more effective utilization of personnel resources and observation. While this would be a major change, in its absence whatever else happens at Willingdon to improve the current situation will likely be ineffective.

There is also an immediate need for improvements to the existing buildings. Bars should be replaced with appropriate and secure plexiglass in windows and doors on the many units where they still exist. Not only would this improve the social environment of the institution, but it would make hanging attempts more difficult.

Additional short-term holding facilities are required for residents who become violent, disruptive or otherwise need "space" away from others to calm down. The lack of such facilities led to the unfortunate handcuffing incident in the gym which is discussed below.

A further immediate improvement would be the securing of the outside track to allow for greater outside sports activity, which is at present restricted to a contained courtyard for most residents.

Further classification and structural issues involve the mixing of remanded and sentenced youth, and the optimum size of unit, either as an individual facility or as separate modules linked to centralized common services and facilities. These questions must be considered as part of a province-wide correctional system review.

Staff Levels

Questions arise as to what is an acceptable interval for patrols, and an adequate staff complement for daytime supervision. While the answers are not always obvious, the issue requires careful analysis.

The staff-to-resident ratio fluctuates with the ups and downs in resident numbers. Bearing in mind both the difficulties posed by the poor design of the existing facility, and the fact that Willingdon's resident population always includes some of the toughest youths in the system, an argument can be made for improving the staff-resident ratio in some areas. Needing immediate review is the adequacy of staff for classification, case management, medical attention, recreational supervision, counselling and weekend programming. Given the changing and complex environment in a youth detention centre, careful review should undertake to

ensure adequate staff training programs are in place for all of these duties.

The diagnosing of depression and the predicting of self-harming behaviour is an extremely difficult task. Most of the youths who fall into this at-risk category have very low frustration tolerance and tend to act on impulse, with few prior indicators. Even when a youth is felt likely to hurt himself, the decision on what kind of special watch to keep, and for how long to maintain the extra supervision is almost impossible to determine. It must be conceded that budgetary considerations are part of the equation; yet it must not be forgotten that the safety of the residents is of paramount importance, and adequate staff levels for psychological assessment, monitoring and treatment must be achieved.

One of the boys who tried to hang himself in January mentioned sometimes feeling depressed in the early hours of the morning. He suggested a specialized counsellor should be available for those occasions. Another youth felt that the regular staff could easily fulfill that role. Nonetheless, it is an idea worthy of further consideration. Shift schedule adjustments could provide a partial solution.

Abuse by Staff

Public allegations have been made that staff mistreatment of residents was occurring. One of the more alarming allegations surfacing along with the self-harm incidents was a charge that staff were taking residents into the gymnasium and suspending them handcuffed to a bar with their toes trailing on the ground. Compounding this serious allegation was the suggestion that staff then threw basketballs at these youths who had been placed in such a vulnerable position.

The Institution promptly convened an internal Board of Enquiry. It was chaired by a member of the community-based Citizens' Advisory Board and included three Willingdon senior staff members.

In its comprehensive investigation, the Board confirmed that two male residents were handcuffed to the chin-up bar in the gymnasium at separate times on the night of January 2, 1989 and that one of the same youths was dealt with in the same way on January 4, 1989. The Board found that on these two occasions the youths had become uncontrollable, were threatening self-harm and were upsetting their own and adjacent units. Normally a holding cell would be used to allow an extremely agitated youth to cool off, but on both

occasions the holding cell was in use. The gymnasium was selected to separate these youths from others and to allow them time to settle down. On all three occasions the youths settled down within about thirty minutes and were returned to their rooms. The residents were checked frequently while in the gymnasium. The Board found that neither boy was cuffed in an uncomfortable position, nor were basketballs or any other projectile thrown at them. The Board concluded that, because of the unusual situation and the risk of self-harm, the use of the gymnasium was an acceptable alternative to the holding cell. The Board did, however, find fault with staff's failure to record the incidents in accordance with the Centre's written policy.

The individual who raised this issue had not been involved in this situation himself, he had simply heard about it. One of the youths involved, when interviewed by our office, said he'd deserved this treatment - he'd been "creating holy old hell" in the unit. He agreed that he had been checked frequently and that he had not been particularly uncomfortable. Care must be taken not to take all statements by residents at face value, given the complex relationships, pressures and motivation that can affect them. In these instances, such action might have prevented a general outburst or serious self-harm to the youth. However, it

should be noted that, other than in the transportation of youths in custody, Correctional policy limits the use of handcuffs to emergency situations. This is appropriate, and as mentioned above, adequate holding facilities would have avoided any need for handcuffs in these cases.

Corrections staff can be under considerable stress. It is imperative that they have adequate numbers, resources, facilities and training to deal effectively with the many challenging situations they face. Inappropriate reaction may well be expected to occur if these needs are neglected.

Education and Programming

While the courts send youth to detention centres like Willingdon and charge the Corrections Branch with keeping them in custody, the Branch's duties clearly do not end there. The Young Offenders Act recognizes that, along with "supervision, discipline and control", young offenders also have "special needs and require guidance and assistance." This means more than counselling. It is self-evident that active, busy teenagers are less likely to be depressed and frustrated. Many of them - for a variety of reasons - have not had successful experiences with education in the community, nor have they been successful in learning the

social skills most of us take for granted. Many residents need help in learning to interact and cooperate with others, and some need special attention to deal with the effects of sexual and other abuse.

The individualized education programs which have been set up for the youths help them overcome the difficulties and deficiencies they have faced in the past. Special topic groups, arts and crafts programs and sports are all avenues for improving interpersonal skills and for bolstering their often-low self images.

Following the Ombudsman's 1985 report, a large number of changes in the areas of education and programming were introduced, and currently there is a wide range of options available to residents. New ideas and plans are on the drawing board. This office will continue to monitor and comment on this positive development.

CONCLUSION

The Ombudsman's office has an ongoing responsibility to investigate individual complaints and incidents at Willingdon, and to monitor the general administration of the facility where systemic problems are indicated.

The vexing problems of self-harm, victimization, inadequate facilities, appropriate staff levels and training, classification and segregation, and containment philosophy require specific attention by the Corrections Branch. They will also be the subject of continuing review by this office.

Of fundamental importance in any consideration of youth correctional issues, is that they not be seen in isolation from general society. Youth in custody bring with them a host of physical, psychological and social needs. When they leave a correctional facility, they face intense economic and personal challenges. The approach of the Ombudsman's office towards the administration of all provincial services to youth is to measure them against a continuum of educational, health, social and correctional needs, whether the youth are in or out of custody at any particular time.

Stephen Owen
Ombudsman
January 27, 1989